11/17	7/2010 14:05	8655945739	'HEAL	TH CARE FACILITY		
DEPAR	TMENT OF HEALTH	I AND HIMAN SERVICES) IEME	IN CARE PACILITY	PAGE	84/21 2: 71/15/201
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	75-51	· 12/25/10	FORM	APPROVE
10 IVICWEN	U UP HENDENCIED	(X1) PROVIDER/SUPPLIER/CLIA			OMB NO	0.0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE S	
1			A. BUILD	ING .	COMPL	ETED
1		445005	B. WING		ļ	
NAME OF	PROVIDER OR SUPPLIER	445235	D. VIIIG		44/	10/2010
			Si	TREET ADDRESS, CITY, STATE, ZIP CODE		10/20) 0
BOOTE	VARD TERRACE NURS	SING HOME	J	1530 MIDDLE TENNESSEE BLVD		
 	т			MURFREESBORO, TN 37130		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	פו	PROVIDER'S PLAN OF CORRECT		
TAG	REGULATORY OR LE	MUST BE PRECEDED BY FULL SC IDENTIFYING (NFORMATION)	PREFIX	I CACH CURRECTIVE ACTION SHOU	li fone	(XE)
	<u></u>	THE PROPERTY OF THE PARTY OF TH	TAG	A CACCO-ARTERENCED TO THE APPE	OPRIATE	DATE
F 164	483 10(a) 492 750	11) 0	<u> </u>	DEFICIENCY		1
SS≒D		(4) PERSONAL	F 164	F164		† — — — — — — — — — — — — — — — — — — —
00-0	I THE STATE OF THE	ENTIALITY OF RECORDS				1
	The resident has the	A windled to	1	The identified employee was individually	in-serviced	11-10-2010
	Confidentiality of his	e right to personal privacy and or her personal and clinical	ļ	By the DON.		}
	records.	or tier personal and clinical		The DON did di	•] .
		•	[The DON did a medication pass audit on	the	11-23-2010
	Personal privacy inc	ludes accommodations,		employee Audit is on employee record.		j
	THE STATE OF THE S	Witten and talantana		Re-education Programming districts		1
	COMMUNICATIONS DA	FSODOL COZO Ministra and		Re-education Progressive discipline will b	e accomplis	hed
	CONTRACTOR OF CALIFIER AL	DO DOCIDANT ARRUMA L		if employee demonstrates continued no	n-compliant	e. 11-23-201
}	Account teaming M6	TROUBLE to provide a securio		All licensed staff, including PRN and staff	!	1
	room for each reside	ent		will be in-serviced on medication Admini	on leave,	12-17-2010
i				by the DON or ADON	suation	
}	Except as provided in	n paragraph (e)(3) of this			ļ	
- 1	AAANALL IIIC IRSKINDIT	IMBV SPRIME		To identify others who are potentially affe	ected	
	Lateract of Del 201191 9	IDO CUDICO FOCArdo 64		the facility administrator will conduct a f	acility	
	individual outside the	facility.	ı	in-service on patient privacy and dignity.	This will	
		·	i	be accomplished for all staff, pro and page	t time by	
]	The resident's right to	refuse release of personal		12-05-2010. Any employee who is on vac	etion or	
	ana antical lecous v	1799 1101 mass	i	leave will have in-servicing prior to enteri	ng the next	
	resident is a guistificht	TI TO SHOTBER books	1	scheduled shift.	•	12-05-2010
} '	mandadi, of recold t	elease is required by law.	ļ			
. (-	The facility must be		i	Medication pass will be audited once a we	ekon j	
	contained in the roots	confidential all information	}	each shift by the DON, or ADON in her abs	ence, then	
l è	he form or storage	ent's records, regardless of pethods, except when		monthly thereafter. (Audit form attached	J)	
r	release is required by	transfer to east	1	A report of audit results shall be given to to	he QA	
F	realthcare institution:	law; third party payment	- 1	Committee, which meets quarterly and con	nsists of	
	contract, or the reside	ent unit party payment	[the Administrator, Director of Nursing, Me	dical Direct	or,
i		116	ļ	Pharmacist, Restorative Supervisor, Dieta	ry Manager,	٠.
		j	i	Activity Director, Social Worker, Environm Supervisor and Maintenance Supervisor.	ental Service	es
jη	This REQUIREMENT	is not met as evidenced		,		
1	y:	to thet as evidenced	į.	The administrator will make twice weekly v	! valkina	11 10 20
ļE	Based on observation	, review of facility policy,		Rounds on random shifts for one month to	observe	11-18-2010
, =	und under view, the tsc!	IIIV tailed to provide privace	[]	For compliance. Any identified deficient	aractice will	
"	anca amministativo W	COICATIONS for one recident	} 1	be addressed by re-education and progres	sive disciplin	ne.
(6	#4) of twenty resident	s reviewed	[7	This will be the responsibility of the adminis	strator and	
				Appropriate department supervisor.		
ļΤ	he findings included:	.]		A record of training and discipline will be ke	pt in the	
· 1		!	1 8	Employee file.		
SURATORY D	RECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNA	TURE			
Um	unda H.	Millias		Aministration .	ÇXI	DATE
4 de 12 a l		9	- (~ Whinimeth	11-12-	/A

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FY ITY

PAGE 05/21 PRINTED: 11/15/2010 FORM APPROVED

CEIAIC	KS FUR MEDICARE	& MEDICAID SERVICES		•	OMB NC	0.0938-039
STATEMEN AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XX) MULT) A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE S	SURVEY
	·	445235	B. WING			
	PROVIDER OR SUPPLIER VARD TERRACE NUR	SING HOME	[11	EET ADDRESS, CITY, STATE, ZIP C		10/2010
(X4) ID PREFIX TAG	・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	fO FREFIX TAG	PROVIDER'S PLAN OF CO FROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE SAPPROPRIATE	COMPLETION DATE
F 279 SS=F	Observation of the 19, 2010, at 8:10 a.m Practical Nurse (LP medications to residuations to residuations to residuations to residuations to residuations to residuation the privacy curtain, the resident's roomfacing the bed of residuation and intercommate was aler Review of the facility Techniques revealed to be exposed, that continues with LPN #8:30 a.m., in the residuation to pull the padministering the metube. 483.20(d), 483.20(k) COMPREHENSIVE	medication pass on November ., revealed the Licensed N) #2 administering lent #4 who had a place. Continued observation led back the covers and estomy tube but failed to draw Further observation revealed mate was seated in a chair sident #4. Continued inview revealed the t and oriented. policy Medication Pass I "ensure anytime resident is curtain is pulled." 2 on November 9, 2010, at dent's room confirmed LPN rivacy curtain prior to ediations via the gastrostomy (1) DEVELOP CARE PLANS	F 184	DEFINERY		
	to develop, review ar comprehensive plan. The facility must develop for each resident objectives and timeta medical, nursing, and needs that are identifiassessment.	elop a comprehensive care t that includes measurable bles to meet a resident's I mental and psychosocial ied in the comprehensive				
1	to be furnished to atta	escribe the services that are ain or maintain the resident's				

11/17/2010 14:05 865594..39 HEALTH CARE FACILITY DEPARTMENT OF HEALTH AND HUMAN SERVICES PAGE 86/21 CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 11/15/2010 FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING " COMPLETED 445235 B. WING NAME OF PROVIDER OR SUPPLIER 11/10/2010 STREET ADDRESS, CITY, STATE, ZIP. CODE BOULEVARD TERRACE NURSING HOME 1530 MIDDLE TENNESSEE BLYD MURFREESBORO, TN 37130 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION TAG DATE DEFICIENCY F 279 Continued From page 2 highest practicable physical, mental, and F 279 psychosocial well-being as required under The staff was in-serviced immediately beginning on §483.25; and any services that would otherwise November 9 through November 13 11-13-2010 regarding the affected residents and on the facility policy be required under §483.25 but are not provided due to the resident's exercise of rights under for aspiration precautions, including the use of straws §483.10, including the right to refuse treatment An audit was done to remove straws from the affected under §483.10(b)(4). Residents. Care Plans were checked and updated by the Care 11-09-2010 Plan Coordinators for all affected residents This REQUIREMENT is not met as evidenced 11-09-2010 To identify others who could be at risk, a list of Based on medical record review, observation, patients with speech therapy recommendations for and interview, the facility failed to revise the care swallowing /aspiration precautions was updated by plans to reflect aspiration preautions for five the Patient Care Coordinator for all residents (#5, #14, #12, #19, #20) of eight residents on aspiration precautions and who are not residents reviewed for residents at risk for to use straws. This list was placed on the MAR, the CNA aspiration. observation books and in a notebook in the dining room and activity room. The DON checked all residents on the The findings included: list to make sure that Precautions were posted in rooms with a cover sheet. Resident #5 was re-admitted to the facility on May 11-09-2010 The list will be updated by the Dietary manager weekly,

4, 2010, with diagnoses including, Recurrent Pneumonia, Diabetes Mellitus, and Alzheimer's Dementia.

Medical record review of the Minimum Data Set (MDS) dated August 31, 2010, revealed the resident had impaired short and long term memory and required assistance with all activities of daily living.

Medical record review of a Speech Therapy discharge note dated September 14, 2010, revealed "...Discharge Recommendations...cont. (continue) asp (aspiration) precautions...thin (liquids) via cup..."

Observation in the resident's room on November 8, 2010, at 10:35 a.m., revealed a sign on the wall

Based on new diet orders. A copy will be given to the patient care coordinators to assure that the care plan is updated for speech therapy recommendations and orders. The speech therapist will re-screen at risk residents Quarterly and revisions will be addressed with diet orders.

A sign will be posted on each wing informing Visitors to check with the charge nurse before offering food or drink to any resident.

12-05-10

11-10-2010

FORM CMS-2587(02-98) Previous Versions Obsolete

Event ID: 3BEL11

Facility ID; TN7502

If continuation sheet Page 3 of 13

4005/037 11/17/2010 14:05 885594_,39 HEALTH CARE FACILITY DEPARTMENT OF HEALTH AND HUMAN SERVICES PAGE 07/21 PRINTED: 11/15/2010 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 445235 NAME OF PROVIDER OR SUPPLIER 11/10/2010 STREET ADDRESS, CITY, STATE, ZIP CODE BOULEVARD TERRACE NURSING HOME 1530 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID fD PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC (DENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG PREFIX (XII) COMPLETION TAG DATE DEFICIENCY) F 279 Continued From page 3 F 279 next to the resident's bed stating "Swallowing Precautions for (resident) Diet ...thin liquids ****NO STRAWS..." Observation revealed the To assure compliance, the AT RISK COMMITTEE, resident requested a drink and the Assistant Consisting of the Dietary Manager or Designee, Director of Nursing (ADON) gave the resident a Director of Nursing or ADON, Care Plan Coordinator, drink from the ice water pitcher using a straw (no Social Worker, Activity Director and Restorative choking noted). Continued observation revealed Supervisor, will review and discuss residents with liquid supplement in a cup with a straw on the aspiration precautions. Any identified non-compliance resident's over the bed table within the resident's will be addressed through patient and family education. reach. Further observation revealed the ADON food consistency waivers, or progressive employee offered the resident a drink of the supplement but discipline. The AT RISK committee will submit a report to the resident refused. the QA Committee quarterly. The QA Committee , which meets quarterly consists of the Administrator, Director Medical record review of the resident's care planof Nursing, Medical Director, Pharmacist , Restorative Supervisor, dated October 2, 2010, revealed no interventions Dietary Manager, Activity Director, Social Worker, Environmental for the resident to not use straws for drinking as Services Supervisor and Maintenance Supervisor. part of the swallowing precautions. Interview with the ADON in the resident's room on November 8, 2010, at 10:38 a.m., confirmed the sign on the wall stated "No Straws" and the ADON gave the resident a drink of ice water using a straw. Interview on November 9, 2010, at 9:40 a.m., at the A B nursing station with the Speech Therapist revealed Swallowing Precautions were posted on

the wall, with NO STRAWS in red letters. Continued interview and review of the resident's current care plan confirmed the precaution "No Straws" was not addressed on the resident's current care plan.

Interview via telephone on November 10, 2010, at 8:00 a.m., with Licensed Practical Nurse (LPN) # 4 revealed LPN# 4 administered the resident's 8:00 a.m., medications on November 8, 2010, and also gave the resident the liquid supplement, "...the resident was having trouble swallowing so I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3BEL11

Facility ID: TN7502

If continuation sheet Page 4 of 13

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HEALTH CARE F/

PAGE 08/21 PRINTED: 11/15/2010

11/17/2010 14:05 ITY DEPARTMENT OF HEALTH AND ... MAN SERVICES

<u> </u>	NO FOR MEDICARE	& MEDICAID SERVICES			CMDAG	M WALKOVE
I STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	0. 0938-039° SURVEY LETED
·		445235	B. WING			
NAME OF	PROVIDER OR SUPPLIER		STD:	EET ADDBAGO AGO COM		10/2010
	ARD TERRACE NUR		15	EET ADDRESS, CITY, STATE, ZIP CO 30 MIDDLE TENNESSEE BLVD URFREESBORO, TN 37130	208	
(X4) ID PREFIX TAG	I ISTOR DEFILIENCE	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD DE	COMPLETION DATE
F 279	got a straw and (res supplement"	sident) drank 1/2 of the	F 279			
	Medical record reviet dated August 23, 20 required assistance living.	ew of the resident's MDS 110, revealed the resident with all activities of daily				
	interventions for the drinking as part of the	resident to not use straws for swallowing precautions.				
}	resident's bed to ale	ember 9, 2010, at 3:30 p.m., m revealed no sign near the rt staff and family to not use resident's swallowing				
	revealed resident #1	per 10, 2010, at 9:00 a.m., at on with the Speech Therapist 4 is not to use straws for a resident's swallowing			•	
	confirmed approache	"Was not addressed on the				
12	viarch 19, 2010, and	mitted to the facility on readmitted on October 13, including Hypertension, Pulmonary Disease,				

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HEALTH CARE F. .ITY

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PAGE 89/21 PRINTED: 11/15/2010 FORM APPROVED

						<u>O. 0938-039</u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
NAME	445235	B. Wil	IG				
NAME OF PROVIDER OR SUPPLIER BOULEVARD TERRACE NURSING	HOME		153	ET ADDRESS, CITY, STATE, ZIP CODE O MIDDLE TENNESSEE BLVD IRFREESBORO, TN 37130	_!11	<u>/10/2010</u>	
TAG REGULATORY OR LSC ID	ENT OF DEFICIENCIES IT BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SMC CROSS-REFERENCED TO THE APPI DEFICIENCY)	MID to DE	COMPLETION DATE	
Medical record review of dated May 18, 2010, review of Speech Therapy for "Chi (cardiac) diet with no hat foods and thin liquids - no Medical record review of recapitulation orders dat revealed an order original 2010, which stated "Regliquids; no straw; no hard foods,"	Above Knee Amputation. If a physician's order realed an order from lange diet to regular rd/crunchy or dry/crumbly to straw." If the physician's ed October 2010, ally written on June 16, ular cardiac diet with thin it crunchy or dry crumbly a Speech Therapy notes realed "Cardiac diet. No lify crumbly foods." the Care Plan dated in on interventions for the second on signs posted its straws. and to the facility on gnoses including neration, Hypertension, rillation. To Dietary Progress Note aled "Remove straws weech Therapy)." view of the dietary notes ived a mechanical soft.	F2	79				

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HEALTH CARE F/ ITY

PAGE 10/21

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES		HEIR CARE FI IIY	PRINTED FORM	10/21 11/15/2019 APPROVE
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL	ULTIPLE CONSTRUCTION DING	(X3) DATE S). 0938-039 BURVEY ETED
		445235	B, WING	G		
NAME OF	PROVIDER OR SUPPLIER		-1	STREET ADDRESS, CITY, STATE, ZIP C		10/2010
BOULE	VARD TERRACE NUR	SING HOME		1530 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130	ODE	,
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	iD	PROVIDER'S PLAN OF CO	ARREST ON A	
PRÉFIX TAG	REGULATORY OR D	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETION DATE
F 279	Continued From page	ge 6	F 27	79		
	use straws.	ew of the current Care Plan ation for the resident to not	. 2.			
	the resident was on	esident's room on November , revealed no signs stating aspiration precautions, what ons consisted of, and the use a straw.			,	
	November 16, 2009.	dmitted to the facility on with diagnoses including reflux Disease. Dementia,				
	Medical record review revealed the resident ground diet with neck	w of the dietary notes t receiving a mechanical soft ar thick liquids.				
	revesied Dist: Wech	w of Speech Therapy notes . (mechanical) soft, nectar r and carbonated beverages,			,	
	Medical record review revealed no intervent use straws.	v of the current care plan ion for the resident to not				
	ษ, 2010, at 4:10 p.m	sident's room on November revealed no signs in the esident was to have nectar traws.				
	omical care Coordin at 10:00 a.m., in the [residents #12, #19 an	ector of Nursing (DON) and ator on November 10, 2010, DON's office, confirmed d #20 were not to have view confirmed care plans				

11/17/2010 14:05 8655942,39

HEALTH CARE FAGILITY

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PRINTED:	11/15/201	ļ
FORM.	APPROVED	•
OMR NO	U038 U20	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;

(X2) MULTIPLE CONSTRUCTION

A. BUILDING R M/Ma

(X3) DATE SURVEY COMPLETED

	<u> </u>	445235	B. WING	a _		440	lama.
NAME OF F	PROVIDER OR SUPPLIER		1	STAI	EET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	10/2010
BOULEV	ARD TERRACE NUR	SING HOME	l'	15	30 MIDDLE TENNESSEE BLVD		
		OHO HOME	ŀ		URFREESBORO, TN 37139		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES		Т	PROVIDER'S PLAN OF CORRECT	TION	1
TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX	ĸ	(EACH CORRECTIVE ACTION SHOL	ULD 85	COMPLETION
<u> </u>			TAG		CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
F 279	Continued From pa	ge 7		_			
}		not use straws for residents	F 27	79			
ļ	#12, #19 and #20.	not use straws for residents		ì	•		
F 322	483.25(g)(2) NG TE	REATMENT/SERVICES -	E 0/	20			
SS≔D	RESTORE EATING	SKILLS	F 32	22			
	Based on the comp	rehensive assessment of a			The identified employee was individually	/ in-serviced	
	resident, the facility	must ensure that a resident		- (¹	By the DON.	•	11-10-2010
	receives the approp	riate treatment and services		-	The DON did a medication area and the		
	to prevent aspiration) pheumonia, diarrhea,			The DON did a medication pass audit on Audit is on employee record.	the employe	e. 11-23-2010
	vorning, denydratio	n. metabolic abnormalities		ļ	•		}
	and nasal-pharynge	al Ulcers and to restore if		F	rogressive discipline will be accomplished	ed if employ] 86 11-33-3010
	possible, normal ear	ling skills.		C	Demonstrates non-compliance.	u.,.p.o/	
ĺ		J		١,	It Program to the second		i
	This RECUIPEMEN	T in		- ["	If licensed staff, including PRN and staff	on leave,	12-17-2010
	ph:	T is not met as evidenced		6	vill be in-serviced on medication Admini y the DON or ADON	stration	
ļ		n, facility policy review, and			, and bole of Abole		
i	THE MEN, THE TACILLY	falled to ensure safety		[İ	
	measures for reside	nts with a gastrostomy tube		N	ledication pass will be audited once a wi	eek for one	11-23-2010
	for one resident (#4) reviewed.	of twenty residents		- 71	month on each, shift by the DON Or ADO	N in her she	ence,
	cyroweu.			L	ien monthly thereafter. (Audit form at	tachod)	•
j	The findings include:	d·		C	report of audit results shall be given to to committee, which meets quarterly and co	he QA	
				Th	ne Administrator, Director of Nursing, M	nsists of	
	Observation during t	he medication pass on		-	riar macist, Restorative Supervisor Dieta	Or Manager	Americal .
[]	ivovember 9, 2010. a	it 8:10 a.m. revealed			rector, bucial Worker, Environmental Co.	DICAL SUBOR	
}	Licensed Practical N	urse (LPN) #2 injected ten ml		M.	aintenance Supervisor for follow-up rec	ommendatio	ons.
į,	resident #4 and cani	ito the gastrostomy tube of rated ten milliliters of					
	Stomach contents C	Continued observation		-			!
1	revealed LPN #2 faile	ed to auscultate the				j	
] (abdomen to determin	ne correct placement of the		-			
	lube,						ł
1.	Davidani, addin a di ma					İ	1
] !	review of the facility	policy Medication Pass		1	·	Į	·
	s econoques tevesied and tesidual in Accept	"a. check for placement with at least 60 ml waterc.				1	
	administer medication	ns by gravityd. flush with		-		}	1
		with mind and min					1

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HEALTH CARE FACILITY

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PAGE 12/21

CLAMA LED	11/15/20
FORM	APPROVE

CENTERS FOR MEDICARE	& MEDICAID SERVICES
	(X1) PROVIDER/SUPPLIER/CLIA

(X2) MULTIPLE CONSTRUCTION A. BUILDING

<u>JMB</u> NO. 0938-039[,] (X3) DATE SURVEY COMPLETED

445235

IDENTIFICATION NUMBER:

B. WING

11/10/2010

NAME OF PROVIDER OR SUPPLIER

<u> </u>	VARD TERRACE NURSING HOME	I	TREET ADDRESS, CITY, STATE, ZIP CODE 1530 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130	
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 322	Continued From page 8 60 ml water."	F 322		
F 431 SS=E	Interview with LPN #2 on November 9, 2010, at 8:25 a.m., in the resident's room, confirmed LPN #2 failed to check placement of the gastrostomy tube, 483,60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		
-	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug		The facility has no residents who use NG tubes. The product was removed immediately. The open suppl were discarded from stock. The Central Supply clerk checked both medication rethroughly.	ies

records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be

labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary Instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can The expired Vitamin C bottle was no longer being used as Vitamin C Is now dispensed through a Med PAC. It was removed from stock.

11-09-2010 The Central supply clerk has been in-serviced on moving oldest stock to the front or top of supply as new stock is relaced. She will check for outdated stock weekly and restock

11-09-2010 The DON will be responsible for assigning and overseeing a charge nurse and the Central Supply person to check the medication rooms and carts for outdated medical supplies, preparations and medications weekly. The treatment nurse will check the treatment cart weekly to assure that any outdated or apened supply is removed 11-25-10

(inservice record attached)

The consulting pharmacist will also check medical supplies in the future when checking the medication room for oversight of compliance Identified staff non-compliance will be addressed through re-education and progressive discipline from the Director of Nursing, or ADON, in her absence. A report of audit results shall be given to the QA Committee, which meets quarterly and consists of The Administrator, Director of Nursing, Medical Director, Pharmacist, Restorative Supervisor, Dietary Manager, Activity Director, Social Worker, Environmental Services Supervisor and Maintenance Supervisor, for review and recommendation. 11-24-20

as indicated.

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HEALTH CARE F.

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES	, ,			PRINTEC	D: 11/15/2010 MAPPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		LE CONSTRUCTION	(X3) DATE (). 0938-039 [,] Survey
	<u>.</u>	445235	B. WIN	G		1	
	PROVIDER OR SUPPLIER /ARD TERRACE NUR	SING HOME	- '-	15	ET ADDRESS, CITY, STATE, ZIP CODE 30 MIDDLE TENNESSEE BLVD	11/	10/2010
(X4) ID PREPIX TAG	(EACH DENCIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API	IOI II D RE	(XS) COMPLETION DAYE
F 431	Continued From pa be readily detected		F 4	31	DEFICIENCY	····································	
	by: Based on observati the facility failed to	NT is not met as evidenced on of the medication rooms ensure drugs and biologicals two of two medication rooms.		•			
	wing on November : revealed one PICC catheter) dressing the opened revealing the sterile and would be	nedication room on the A/B 9, 2010, at 10:00 a.m., (peripherally inserted central it had the outer covering e wrapped contents which are come contaminated if open to lif and available for resident	-		• •		
	revealed one second the shelf and available Further observation revealed five package tubes, #16 French 3 January 2009**, and a	on of the medication room dary intravenous set open on ole for resident use. of the medication room des of Ross enteral feeding 6 inches, with "Use by one package with "Use by d in large black letters on the					
	on November 9, 201 medication room, co secondary IV kits we six packages of ente	Licensed Practical Nurse) #1 0, at 10:30 a.m., in the nfirmed the PICC line and the open an the shelf, and the trail feeding tubes were available for resident use.					

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445235

HEALTH CARE FACILITY.

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11/10/2010

DEPARTM	ENT OF HEALTH A	AND HUMAN SERVICES
CENTERS	FOR MEDICARE 8	MEDICAID SERVICES

CENTERS FOR MEDICARE	& MEDICAID SERVICES
STATEMENT OF BEFORESTANCE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING B, WING_

NAME OF PROVIDER OR SUPPLIER

BOULEVARD TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP GODE 1930 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) [EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5)		
F 431	Continued From page 10	F 431			
•	Observation of the Medication room on C wing on November 9, 2010, at 10:35 a.m., revealed one bottle of Vitamin C 500 mg (milligram) tablets, 1000 tablet bottle, which had been opened and some tablets removed, with an expiration date of October 2010 on the shelf and available for resident use.				
F 514 SS=0	Interview with LPN #1 on November 9, 2010, at 10:50 a.m., in the medication room, confirmed the bottle of Vitamin C tablets was expired and still on the shelf available for resident use. 483.75(I)(1) RES RECORDS-COMPLETE	F 514	The DON did individual in-service with the nurses who were involved.		
ŀ	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.		To identify other residents at risk, the DON implemented an audit formto be used daily by the A/C lead nurse and the 8 Wing charge nurse. 11-28-201 All licensed staff will be in-serviced by the DON and ADON		
	The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.		The 7-3 8 wing charge nurse and the A/C lead nurse. 11-28-2010 will do daily audits for PRN medications for 4 weeks, then weekly thereafter. The DON will oversee the audit process. Any identified non-compliance will be addressed by the DON or ADON through re-education and progressive discipline.		
	This REQUIREMENT is not met as evidenced by: Based on medical record review, facility document review, and interview, the facility falled to document administration of pain medication accurately and completely for one resident (#9) of twenty residents reviewed.	;	A report of audits will be given to the QA committee ,! which meets quarterly and consists of the Administrator, Director of Nursing, Medical Director, Pharmacist, Restorative Supervisor, Dietary Manager, Activity Director, Social Worker, Environmental Services Supervisor and Maintenance Supervisor, for review and recommendations.		
-	The findings included:				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE F. _ITY

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<u> </u>	KS FUR MEDICARI	E & MEDICAID SERVICES		•	OND NO	M APPROVE	
STATEMENT OF DEFICIENCIES (X1) PROVID		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIE	PLE CONSTRUCTION	(X3) DATE!	OMB NO. 0938-039 (X3) DATE SURVEY	
			A. BUILDING	3 <u></u>	COMPL	LETED	
		445235	B. WING				
NAME OF	PROVIDER OR SUPPLIER				11/	10/2010	
	/ARD TERRACE NUR	SING HOME	15	eet address, city, state, zip co 330 Middle Tennessee blyd URFREESBORO, TN 37130	IDE '		
(X4) ID PREFIX TAG	REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CURRECTIVE ACTION CROSS-REFERENCED TO THE DEFIDIENCY)	SHOULDEE	(X5) COMPLETION DATE	
F 514	Continued From pa	ige 11	F 514			 	
	with diagnoses inclicongestive Heart Finsufficiency, Benig Osteoporosis, Perig Gastroesophageal i Mellitus, Coronary Acerebrovascular Achemiparesis, Abdol Coronary Artery Byt Medical record reviedated October 13, 2 "Hydro-APAP 5/325"	Coident with Right Minal Acritic Angungmans					
	Administration Reco 2010, revealed a part 11:00 p.m. to 7:00 a assessment of "4" of shift but no document administered (Pain a scale of 1 - 10 with 10 Continued medical modical medical reconstruction of part 12:00 p.m. documentation of part 14" on the 3:00 p.m. documentation of part 15" or a pain assessment of "5" or a pain assessment of 1:00 p.m., shift but 1:00 p.m.	ew of the Medication and (MAR) for October 17, in assessment of "3" on them., shift and a pain in the 7:00 a.m. to 3:00 p.m., intation of pain medication assessment is done on a 10 being the worst pain.). ecord review of the MAR for exceled a pain assessment of to 11:00 p.m., shift but no the medication administered. and review of the MAR for 25, 2010, revealed a pain in the 3:00 p.m. to 11:00 p.m., the documentation of pain ered. Further medical record of October 29, 2010, revealed of "4" on the 3:00 p.m. to no documentation of pain ered. Continued medical					

HEALTH CARE F LITY

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:					- OMB M	<u>D. 0938-039</u>	
		(X2) MULTIPLE CONSTRUCTION			(XS) DATE SURVEY COMPLETED		
		A. BUII	A. BUILDING				
		445235	B. WIN	iG_			
NAME OF	PROVIDER OR SUPPLIER		 			11/	10/2010
BOULE	VARD TERRACE NUR	SING HOME		STF	REET ADDRESS, CITY, STATE, ZIP CODE 1530 MIDDLE TENNESSEE BLVD		
			į	N	AURFREESBORO, TN 37130		
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	<u></u> -			
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	X (EACH CORRECTIVE ACTIO	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOPE	NA 호텔스테이 D DD: I A A A	
			TAG		CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE
F 514	Continued From page 12						
•	record review of the	MAR for October 24 ages	F 5	74			4
	Light of Dally See	SESSIMONT OF "A" AR SEA T.A.S.		i			1
	(a.m. (0 0.00 D.M e	1007 Nut no documentata					1
	i Main inicalication ami	Ministrad Euskaansassi		Ì			}
•	I LEGALOR OF THE	PRIMIT FOR MOUVEMENT A ARKA		- 1			
				i			
	p.m. to 11:00 p.m., shift but no documentation of pain medication administered.						
	have unedication 901	ministered,					
	Review of the facility	V Dolley PPN Medication		ı	•		
	Review of the facility policy PRN Medications revealed "When giving PRN (as needed)			İ	-		
	THE CHARLOTTS. THEY IT	ITIST TO COOK ON ON THE IT		ļ	•		
	warm of the MAKE I	OB OBIC 2nd time the		- 1			
	THEORESTION Was give	Of the medication					
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	Les annouses in 1	IGS Medication and the					
	aurera of the Utilize S	administering the medication."					1
1	Interview with the Dr	ON revealed the pain		-			}
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